## CITY OF MEMPHIS INSURANCE AFFIDAVIT (Instructions to Complete the Affidavit)

Please print your name on the top line of affidavit.

- 1. Check YES if you are confirming that you, the City of Memphis employee/retiree, have signed all forms and that you are the covered employee/retiree. Otherwise, check NO. Please be advised that this Affidavit will be null and void if the signatures on the forms are not the true signature(s) of the employee or retiree of the City of Memphis. All other approved signatures must have forms on file in the Health, Wellness and Benefits Service Center for Power of Attorney.
- 2. Check YES if you are adding or extending coverage for any dependent between the ages of 19 and 26. Otherwise, check NO and submit a completed notarized affidavit. Please be aware that if a dependent child is between the ages of 19-26 and has access to or is currently enrolled in a health insurance plan outside the city government, they cannot remain on your coverage. If you are adding or reinstating a dependent between the ages of 19-26, you must complete additional paperwork.
- 3. Check YES if you or any family member covered on your medical plan use nicotine products such as cigarettes, snuff, chewing tobacco, etc. A tobacco surcharge will be added to your medical premium for tobacco usage by you or any covered family member. Otherwise, check NO.
- 4. Check YES if your spouse is enrolled in another medical health plan. There will be no Spousal Surcharge. List details on the Other Insurance Information Form.
- 5. Check YES if your spouse has access to other medical insurance but chooses not to enroll.

ATTN: The affidavit must be notarized before any changes can be made to your premium!



## CITY OF MEMPHIS INSURANCE AFFIDAVIT

STATE OF TI	ENNESSI	EE )			
COUNTY OF	SHELBY	)			
I, hereby affirm	that I am	over the age of 18 years o	, after being do	uly sworn according to law, do	
	be held li	able to repay all claims an	rue under the penalties of pend the City of Memphis has the	rjury. If I am found guilty of ne right to terminate my	
Please check Y	ES or NO	) for each question:			
YES	NO				
			ll signatures on the Medical, the true signatures of the ret	Dental, Vision, Life and iree or employee of the City of	
		ages of 19 and 26 wh	e you attempting to add or extend coverage for dependent(s) between the es of 19 and 26 who have no access to health insurance or is currently not ured under other health insurance coverage? Additional paperwork is CQUIRED.		
		products including, tobacco surcharge w	Do you or any family member covered on the medical plan use nicotine products including, but not limited to cigarettes, snuff, chewing tobacco, etc.? A tobacco surcharge will be assessed to your medical premium for tobacco usage by you or any covered family member.		
			Is your spouse enrolled in another medical plan? List details on the Other Insurance Information Form.		
		enroll?	Does your spouse have access to other medical insurance but choose not to enroll?  A spousal surcharge will be added to your medical premium		
Please provide	the name	e, address and telephone n	umber of your spouse's emp	loyer(s):	
Company Nan	ne:				
Address:			Telephone Number:		
FURTHER AI	FFIANT S	SAYETH NOT.			
Social	Security	Number	Employee Retiree	Signature (Please check one)	
SWORN TO A	AND SUB	SCRIBED before me this	day of	, 20	
Notary Public			My commission expires		